

CONTACT INFORMATION

Client Full Name: Date Of Birth :
D D M M Y Y Y

Social Security Number:

Gender: Male Female

Address :

Phone: E-mail:

Name of Caller (If calling for someone else): Relationship:

Deceased: Date Deceased: State Deceased:

Emergency Contact Name: Emergency Contact: Emergency Contact Relationship:

INTAKE FORM

Have you ever been represented regarding Paraquat? Yes No

Have you mixed, sprayed, transferred, or worked in Paraquat manufacturing? Yes No

Paraquat Type:

Do you or a loved one have pesticide license? Yes No

Worked for someone with pesticide license? Yes No

Have you lived or worked on a farm where Paraquat was used? Yes No

Name of Farm:

Farm Address:

How were you exposed to Paraquat? Yes No

What was the purpose of Paraquat use/application?

How often were you exposed to Paraquat? Yes No

When 1st exposed:
D M M Y Y Y Y

When last exposed:
D M M Y Y Y Y Usage Type:

Symptom Start Date: Type of Injury/Symptoms:

Type of disease diagnosed with?

Date Diagnosed:
D M M Y Y Y Y Where diagnosed name:

Where diagnosed address:

Where diagnosed phone: Where treated name:

Where treated address:

Where treated phone: Medication:

Treatment: Treatment Date:
D M M Y Y Y Y

Name of Treatment Facility:

Address of Treatment Facility:

Phone Number of Treatment Facility:

Exposure Causation Knowledge:

Have you ever had a DaTscan/MRI to help diagnose your Parkinson's Disease or symptoms? Yes No

Call Recording Link: